MATERNITY CARE PROGRAM
ADMINISTRATIVE REVIEW REQUEST FORM

Please attach original red drop-out claim forms for the recipient listed. If the claim is not included, this form will be sent back to you. This will cause a delay in administrative review process and claim processing. Primary Contractors are required to forward claims received from subcontractors to Medicaid within 5 working days.

Recipient Name _____ **DOB** _____

Medicaid # _____ **County Code** ____ **EDC** _____

Type (check one) _____**Dropout** _____**Outdated claim** _____**Other**

Explanation for review request: _____

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Claims Attached:

- ☐ **Physician**
- ☐ **Clinic Antepartum Provider** ☐ **Anesthesiology**
- ☐ **Radiology/Ultrasound** ☐ **Other**

Date Dropout Fee Claim Filed?: ☐ **Yes** ☐ **No** **Date:**_____

Primary Contractor: _____ **District:** _____

Submitted By: _____ **Phone No.:** _____

Medicaid Use Only:

Date Reviewed: _____ Date Sent to EDS: _____ Date Returned to PC for add info: _____

Notes by Reviewer:

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